CMN for Lumbar-Sacral Orthosis Back Support

Patient Name: ____ Patient DOB: ____________________________

Medicare # ____ Patient Phone: ____________________________

Treating Physician: ____

Physician Address: ____

City: _____________________________________ State: ______________ Zip: _________________________________

Physician Phone: _________________________________ Physician Fax: ___________________________________

INSTRUCTIONS: The above named patient has requested that you fill out this order form. Please complete *entire* form and fax to the number below. Per Medicare guidelines we are required to obtain **progress notes** along with this **signed RX** and **qualifying diagnosis code(s)** for product sought by your patient. Please make sure the supporting documentation is faxed to validate **medical necessity** in order to facilitate your patients' request. Unfortunately, without these necessary documents we will not be able to supply the product requested by your patient.

Item(s) to be ordered:

A lumbar-sacral orthosis ________ L0627 ________L0637 or ________
L0637 is covered when it is ordered for one of the following indications:

Please indicate which of the following conditions apply to the patient. Check all that apply.

☐ To reduce pain by restricting mobility of the truck: or

☐ To facilitate healing following an injury to the spine or related soft tissues: or

☐ To facilitate healing following a surgical procedure on the spine or related soft tissue: or

☐ To otherwise support weak spinal muscles and/or a deformed spine.

Please choose ICD-10

☐ M12.90 Arthropathy	☐ M19.90 Osteoarthritis, Degenerative	☐ M05.9 Arthritis, Rheumatoid
☐ M25.60 Joint Stiffness	☐ S33.5XXA Lumbar Sprain/Strain	☐ M54.5 Chronic Low Back Pain
☐ M62.50 Disuse Atrophy	☐ M62.81 Muscle Weakness	☐ _______________Other **ICD-10**

Estimated length of need (# of months) ___________________ (99 = lifetime)

This patient is being treated under a comprehensive plan of care for arthritis/pain. I, the undersigned certify that the above prescribed is medically necessary for the patients' overall wellbeing. In my opinion, the following orthotic/arthritic relief products are both reasonable and necessary in reference to accepted standards of medical practice in the treatment of the patient's condition and/or rehabilitation.
I certify that the patient's medical records reflect the need for the item ordered and will be made available upon request.

Physicians Signature: ________________________ NPI# __________________ Date: __________

****PLEASE FAX THIS ORDER TO 310.330-0199 ****

DW Medical Supply
Equipment & Supplies
(310) 330-0199